OUTPATIENT TREATMENT OF THE ALCOHOLIC

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Alcoholism is a distressing condition which if unchecked leads to progressive deterioration of mind and body.

If we survey the situation as a whole, the striking fact emerges that it seems to be a problem in all countries. It is difficult to obtain exact figures of the incidence of alcoholism in any particular country. It is quite certain however that it is highest in the U.S.A. where it has been suggested there are five million addicts. When it is realized that for each alcoholic four or five people are implicated, as parent, child, husband, wife, employer, employee, and so on, the magnitude of the suffering involved is at once apparent. In the U.S.A. it is described as a " national emergency ". But it must not be thought that alcoholism is a phenomenon of the West only. Russia and her satellites have their troubles too. Many of you will have read that Mr Khruschev threatened severe penalties for the drunkard " who disfigures family life ". Poland's consumption of vodka is $2\frac{1}{2}$ times the pre-war level, and the State has had to appeal to the Church to help fight the evil.

Czechoslovakia reported that alcoholism among youths and even school children has spread like an epidemic. In the United Kingdom a figure as high as 300,000 has been suggested. And again I would remind you of the disruptive havoc each case causes, so we can safely say that alcoholism affects, directly or indirectly, several hundred thousand people of all classes.

Now I want to emphasize as strongly as I can that this largely represents an unnecessary waste of human life and happiness, to say nothing of the economic loss due to disrupted work. For, contrary to what is so often held, alcoholics can be helped. Many of them are intelligent, sensitive people, and we can certainly say from our own experience it is well worth while trying to help them to become active useful citizens. But when we turn to examine the provision made for their treatment, we find that this is meagre in the extreme. Now this is not intended as a criticism of the N.H.S. It is not limitless in its capacity. But at present there are only two

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or three special units for the treatment of alcoholics within the N.H.S. For the rest, alcoholics requiring help are chiefly admitted to mental hospitals and scattered haphazardly in ones and twos here and there. Yet experience clearly shows that they do better as a group treated in a special unit.

The Advantage of Ambulatory Treatment

There is a further important consideration: namely, that they should not be actually admitted to a hospital unless the circumstances of their particular case demand it. Surely it is an advantage to treat the alcoholic as an outpatient, as is done at the Reginald Carter Foundation where he can remain in contact with his work and home, instead of being completely uprooted. If any form of social rehabilitation is required this can be started at once instead of having to be delayed for weeks or months. Not every case is suitable for outpatient treatment. In brief it is cases in the early and middle stages of the alcoholic process, and those whose pre-alcoholic personality was reasonably stable. Since these are the cases constituting the majority of the alcoholic population, much can be done on an outpatient basis.

" Drying Out " Process

How should treatment be started? The alcoholic has to stop drinking completely and abruptly. " Tapering off " measures are unsatisfactory. It is explained that the true alcoholic is incapable of drinking in moderation—he cannot just cut down—but must avoid alcohol completely. This may seem drastic, but in practice is not so difficult. Patients often fear withdrawal symptoms or even D.T.'s. But D.T.'s only occur when there has been a period of continuous intoxication lasting several weeks. In practice we generally provide a tranquillizer for the first 72 hours. We restrict the use of tranquillizers to a minimum owing to the ease with which a patient can change from alcohol to other addictions.

It is the fashion in treating alcoholics to administer vitamins in high dosage, particularly members of the B group. However, the evidence indicates that in the intoxication stage and in the abstinence syndrome, nutritional factors are of little or no importance. The alcoholic is notoriously casual about his eating habits and is liable to develop nutritional disorders and whenever there is a possibility of this we give members of the B group: B1, nicotinic acid, riboflavine, pyridoxine, pantothenic acid, in order to prevent the onset of degenerative changes in the brain and nervous system. Serious and permanent damage to the brain is fortunately a relatively uncommon complication of alcoholism, found only in the later stages. The liver degeneration found in alcoholics is also nutritional due to

an absence of protein. This requires a diet rich in protein for its correction.

Breaking the Habit

The above measures constitute the so-called "drying-out" process. It is obvious that by themselves they are likely to be insufficient, for the alcoholic pattern of response is too strongly impressed upon the nervous system. Steps have to be taken to disrupt this pattern, to break the habit in some way. In the outpatient clinic we have found antabuse most useful. When the alcoholic takes antabuse daily, little or nothing untoward happens unless he drinks. But if he does so then the antabuse interferes with the metabolism of the alcohol so that acetaldehyde accumulates in abnormally high concentration and this produces a disturbing reaction which prevents further drinking. The patient has therefore only to make one decision each day, namely, to take his antabuse, instead of the innumerable decisions that arise each time he is in the neighbourhood of a drink. But antabuse cannot be used in every case; with some patients there are physical reasons that preclude its use. Patients with disturbances of heart function, for instance, cannot tolerate the cardio-vascular reaction it produces. Others are psychologically quite unsuited for this form of treatment, and revolt against what is essentially a chemical straightjacket. The former can sometimes be treated with a newer preparation, temposil, which acts in the same way as antabuse but produces a less severe reaction. For the latter type of case it is necessary to employ a quite different method of trying to break the habit, and under outpatient conditions the use of apomorphine by mouth is the most satisfactory. By the buccal route treatment can be carried out by the patients themselves in their own homes.

Apomorphine has long been known to medicine as a drug that produces vomiting. It is related to morphine but on account of its unpleasant side effects is not addiction producing. Apomorphine was originally given by injection to cause vomiting while giving the patient alcohol, thereby endeavouring to produce an aversion to alcohol by the development of a conditioned reflex. As a result of later work, it is now believed that apomorphine takes away the craving for alcohol independently of its association with the vomiting mechanism. In other words, sub-emetic doses, doses that do not give rise to actual vomiting, have a quietening effect. We do not really know the precise means whereby apomorphine acts, but the fact remains that it is certainly useful when given by mouth. Apomorphine is not only useful for breaking the habit initially, but also for preventing subsequent relapses, for apomorphine allays the desire for drink which occurs periodically as tension mounts. If given in the premonitory stage of extreme restlessness and irritability,

the paroxysm can be overcome, or if the patient has actually started to drink, the bout can generally be terminated and apomorphine is even useful as an initial approach to the patient who first comes to the clinic when still drinking and in a state of intoxication.

Psychological Treatment

But even if the habit be broken, unless the underlying psychological disability, which originally caused the patient to drink, be corrected, tension will sooner or later build up once again, and the patient will either resume drinking, or experience such a period of irritation and restlessness, called a "dry drunk", as to make sobriety worthless. Therefore, if he is to remain a contented abstainer for any length of time treatment must now be directed to correction of the underlying psychological disharmony.

I do not propose to discuss the psychology of the alcoholic in any detail. But I would like to say a word or two about the neurotic alcoholic as we see him in the outpatient clinic. Neurotic, that is to say, in distinction to the basically psychotic or psychopathic personality. A wide variation in personality is seen. Two types that superficially appear to be absolutely dissimilar stand out. On the one hand, the emotionally immature, passive, dependent person. On the other hand, the boastful, aggressive, bombastic personality. What have these two types in common? I suggest they have this in common: there is a conflict between what they would like to achieve in the world, their "assertions", as Lakin Phillips expresses it, concerning themselves, and that which they actually experience. That is to say their assertions are not confirmed. Obviously there are two solutions to the conflict. One is the false solution provided by alcohol, for the effect of alcohol is merely to produce a descent from the world of reality and responsibility into a world of fantasy and irresponsibility, where events appear to adjust themselves to one's demands without effort. And the alternative solution is for the alcoholic personality so to become transformed as to become capable of finding satisfaction and expression in the world of experience. Therefore to physical rehabilitation the clinic must endeavour to add psychological rehabilitation. The object is not just to give the patient greater theoretical understanding of his psychological problems. We have to try to re-orientate him to a real social world at the same time as we provide psychological retraining. Therefore our part in this transformation is as it were to hold a mirror to the patient so that he can begin to understand himself. In the two types we have been considering the essential fault common to both is an underlying narcissism or self-concern that makes them too vulnerable to life. Terms such as egocentricity, intolerance, sensitivity, undersocialization, defiant individuality,

grandiosity, have been used by various writers to describe the character traits of the fully established alcoholic personality. These all stem from what the American psychiatrist Tiebout calls an " inflation of the ego ", and, says Tiebout, this requires "ego deflation at depth."

Improved Personal Relationships

There must be a gradual transformation from a self-centred, defiant personality, into one who is able to get along with his fellow men, and to meet them on their terms rather than to force them to conform to his. This requires practice—constant practice and acceptance of a truly personal relationship by the alcoholic in his social commitments. As Dr Glatt has pointed out: " The alcoholic is often originally driven to drink because he feels unable to form human relationships without a social lubricant, and he has gradually withdrawn more and more from society because of drink. He has therefore to practice the art of getting on with other people." As Dr Sheldon F. Bacon of Yale expressed the same idea: "He must start to practice reciprocal social relationships and begin to act in socially acceptable ways instead of just dreaming and suffering and trying to escape through alcohol." It is the function of the clinic to encourage this practice of personal relationships. To provide, again in the words of Dr Glatt, " Here and now, treatment of social difficulties in a realistic life-like setting." This is the supreme advantage of the outpatient clinic which can not only provide the group activities which are so important a feature of treatment in the alcohol unit within a mental hospital, but in addition the outpatient clinic can facilitate this essential resocialization in the world by helping the patient to develop more mature attitudes towards interpersonal relationships.

The whole object, then, of treatment is to help the patient to become a living person in a world of living people. Contrary to what is so often believed much may be done to help the alcoholic in his own home.